Illinois Rural HealthNet

Improving health care through connectivity

April 18, 2012

VIA ELECTRONIC FILING

Ms. Marlene H. Dortch
Secretary
Federal Communications Commission
445 12th Street, SW
Portals II, Room TW-A325
Washington, DC 20554

RE: ***Rural Health Care – Moving from the Pilot Program to the Primary Program***
WC Docket No. 02-60

Dear Ms. Dortch:

The Illinois Rural HealthNet hereby provides notice of an oral *ex* parte presentation in connection with the above captioned proceeding. The Illinois Rural HealthNet (IRHN) is one of the participants in the FCC's Rural Health Care Pilot Program.

On April 17, 2012, Douglas G. Power, Assistant Project Coordinator of the IRHN, and Senior Consultant and Research Associate of Northern Illinois University's Broadband Development Group, met with Christianna Barnhart, Chin Yoo, and Linda Oliver, each of whom is Attorney Advisor in the Telecommunications Access Policy Division of the Wireline Competition Bureau in the Federal Communications Commission. This notice is being made, and the comments are filed, solely on behalf of the Illinois Rural HealthNet. Following is a summary of the topics, and then details of the content of our discussion:

Summary of Topics:

- Topic A: We discussed the fact that the Rural Health Care Pilot Program (RHCPP) allows for non-traditional service providers, but that the RHC Primary Program does not currently allow for non-traditional service providers. By not allowing non-traditional service providers to be eligible for Primary Program consideration, considerable burden and financial risk is loaded onto the prospects for successful sustainability of the entities established by the RHCPP. The IRHN recommends that non-traditional service providers be eligible in the Primary Program.

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- Topic B: We discussed the Notice of Proposed Rule Making (NPRM) of July 15, 2010, and noted the positive aspects of Paragraph 93, specifically the recommendation to replace the existing internet access program with a new "'health broadband services program,' which will subsidize 50 percent of an eligible rural health care provider's recurring monthly cost for any advanced telecommunications and information services..." ; and also Rule 54.635 on Eligible Service Providers. These recommendations in the NPRM are strongly supported.

- Topic C: We discussed our concern that there may be confusion among rural health care providers as to whether such HCPs will be able to participate in the RHC Primary Program, after such time as the Pilot has been completed. While the Pilot Program is accomplishing its objectives in creating high-speed broadband in geographical areas where either none was available, or such broadband was far beyond the financial reach of small rural hospitals, after such time as the Pilot is completed, the RHCs will still benefit strongly from individual hospital participation in the Primary Program, and the RHCs are asking for our assurance that this will be the case.

Details from our discussion:

Topic A:

Unlike the Primary Program, the RHC Pilot Program allows for "non-traditional" service providers. The Illinois Rural HealthNet (IRHN) is a consortium of eligible health care entities that was awarded $21,063,528.00 by the FCC. The IRHN is implementing a fiber-based network throughout the State of Illinois, containing well over 1000 miles of fiber backbone and fiber laterals. Five hospitals are currently connected, and construction is under way to connect 43 additional HCPs, many by the end of this year. Discussions are also under way with an additional 40 HCPs, expected to be connected not later than early 2014 for a total of 80-plus HCPs, and the IRHN sustainability plan allows us to plan for ongoing growth in future years.

Health Care Providers (HCPs) connected to the IRHN are charged a monthly fee ranging from $750/month to $1200/month, for services ranging from 100Mbps symmetrical to 1Gbps symmetrical. The RHCs pay their monthly fee directly to the IRHN. A fiber-based network this extensive, throughout the State of Illinois, would not be possible at the IRHN funding level were it not for the fact that the IRHN, a not-for-profit 501(c)(3), issued 11 separate Requests for Proposals, to obtain cost-efficient fiber connectivity and pricing, much of which has been made available to the IRHN by non-traditional service providers. The RHCPP's allowance of non-traditional providers is one of the most significant and positive elements of the RHCPP Order.

The IRHN is a hybrid network that consists of dark fiber, leased lambdas, leased fiber-based bandwidth, fiber laterals, and point-to-point wireless, with the segments connected with optical switching equipment, all of which is managed and operated by a Network Operations Center. These segments were then "stitched" together into a transparent-to-the-user seamless high-speed network.

The RHCPP Order states that HCPs can move from the Pilot Program to the Primary Program. However, the Primary Program is restricted to traditional service providers. Consequently, it does not appear that the IRHN is eligible as a service provider in the Primary Program.

This fact is discouraging some rural HCPs from joining the IRHN. For others that have joined, the huge advantages of cost-efficient high-speed broadband still presents a budgetary challenge, and they are requesting that they be allowed to participate in the Primary Program. Typically, a rural HCP may have one T-1 circuit, such that the monthly cost, after including the Primary Program reimbursement, is approximately $300 dollars. The increase in cost to $750, $1000, or $1200 is difficult for a small rural hospital to budget.

Additionally, the inability of rural HCPs to participate in the Primary Program impacts negatively on the sustainability of the IRHN itself, which depends on the monthly recurring cost of connection as its operating cash flow.

Recommendation:

The IRHN recommends that the Primary Program be modified slightly, to allow for non-traditional service providers, as well as traditional service providers.

However, this filing is not aimed solely at a request for a waiver from the "traditional provider" rule, in that there would still be the further obstacle of the maximum allowable distance rule. The IRHN is a broadband network encompassing hundreds of miles.

Details of Topic B:

The specific objective of this Topic B comment is to clarify the meaning of Paragraph 93 of the NPRM of July 15, 2010, docket 02-60. The IRHN strongly supports the intent of this Paragraph, as we understand its wording, and we seek merely to confirm that our understanding is correct.

This paragraph deals with what is called "Internet Access" in some earlier documents, and uses instead the term "broadband".

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93. *Eligible Access and Transport Services*. Pursuant to section 254(h)(2)(A), and consistent with the recommendations made in the National Broadband Plan, we propose to replace the existing internet access program with a new "health broadband services program," which will subsidize 50 percent of an eligible rural health care provider's recurring monthly costs for any advanced telecommunications and information services that provide point-to-point broadband connectivity, including Dedicated Internet Access.

There are a number of items connected with this language that we discussed:

The first item to be clarified is as follows: The language includes the phrase "services that provide point-to-point broadband connectivity..." The IRHN, like most networks, provides point-to-multipoint broadband connectivity. That is a large part of the point of the IRHN, and also a large part of the business plan that allows for the IRHN to provide lower cost to high speed broadband than would otherwise be available in rural areas. We assume that the intent of this language was to highlight the high-speed elements, and not to restrict this paragraph's suggestions solely to point-to-point connections. A string or daisy-chain of separate point-to-point connections is not an efficient way to build a high-speed network.

Recommendation for clarification of Paragraph 93:

We would like to propose a simple clarification: In the last part of Paragraph 93, insert "and point-to-multipoint" -- such that the phrase reads:

"for any advanced telecommunications and information services that provide point-to-point **and point-to-multipoint** broadband connectivity, including Dedicated Internet Access."

We believe that the above phrasing would eliminate any possible confusion, and thus strengthen the intent of the paragraph.

The second item we discussed for clarification has to do with eligible service providers. The language proposes to replace the existing internet access program with a new "health broadband services program," which is exactly what the IRHN is providing. The IRHN is strongly in favor of this approach, and we seek only to ensure that the IRHN hospitals and clinics, and other health broadband services programs, will be able to participate in the Primary Program in these regards. Our network connects health care providers to the internet, in a manner that reduces cost and thus allows for higher speeds than would otherwise be available to IRHN locations.

The language proposes to subsidize 50 percent (up from the current 25%) of an eligible rural HCP recurring monthly costs for "any advanced telecommunications and information services that provide (point-to-point) broadband connectivity, including Dedicated Internet Access." The IRHN provides an

advanced telecommunications and information service, the IRHN provides broadband connectivity, and it provides Dedicated Internet Access.

We therefore believe the IRHN (and other Pilot Program projects) meets the definition as outlined in Paragraph 93, and as defined in 54.635:

54.635 Eligible service providers.
Broadband access services may be provided by a telecommunications carrier or other qualified broadband access service provider, provided that the health care provider selects the most cost effective option to meet its health care needs in accordance with § 54.603.

The IRHN believes that it meets the standard of a qualified broadband access service provider as described in the FCC's Pilot Program Order adopted on November 16, 2007. The IRHN has been funded by the FCC and the State of Illinois in that role, and the IRHN has selected and continues to select the most cost efficient options to meet the rural HCPs' health care needs, as was stipulated in the Pilot Program Order and as stipulated in Paragraph 54.635. The FCC and USAC have established an environment that assures that (broadband) service providers, both traditional and non-traditional, will follow and comply with FCC and USAC requirements for the Pilot Program. For example, each of the IRHN vendors has signed the Service Provider Certification. The IRHN believes that, by carrying out the required FCC/USAC procurement procedures, the IRHN must logically, by that standard, be considered as a qualified broadband access service provider, insofar as the RHC Primary Program is concerned.

Recommendation for clarification of 54.635:

We would like to propose a simple clarification, such that the first part of 54.635 reads:

"Broadband access services may be provided by a telecommunications carrier or other qualified broadband access service provider, **such as those established by a Pilot Program(s) of the Federal Communications Commission**, provided that the health care provider ..."

The third item in Topic B that we discussed has to do with multi-year contracts, 54.641:

54.641 Multi-year contracts
(a) Participants in the health broadband services program are permitted to enter into multi-year contracts for recurring broadband access services, but may not receive funding commitments from the Administrator for more than one funding year at a time.
(b) Multi-year contracts entered into by a rural health care provider after complying with the competitive bid requirements of § 54.603, are deemed to have "evergreen" status. Health care providers do not have to rebid for services during the term of a multi-year contract with evergreen status However, health care providers may not add services to a multi-year contract or extend the term of a multi-year contract and retain "evergreen" status. Such modifications to a multi-year contract are deemed a new request for

services, and require that the health care provider rebid the services in compliance with the provisions of § 54.603 and select the most cost-effective service provider.
(c) All program participants, including those covered by evergreen contracts, must submit a request for support each funding year to continue receiving funding from the health broadband services program for recurring broadband access services. Requests for support each funding year are subject to the program funding and prioritization rules set forth in § 54.675. Rural health care providers with multiyear contracts do not have a priority preference over other rural health care providers seeking support from the health broadband services program in any funding year.

We believe that the IRHN, having complied with competitive bid requirements, is correctly deemed to have "evergreen status" -- and as such, HCPs connected to and by the IRHN should be allowed to submit requests for support for each funding year without the need for a rebid of services.

Details of Topic C:

The IRHN requests that the Health Care Providers that receive their internet access services from the IRHN, and that are billed monthly by the IRHN for these services, be allowed to participate in the RHC Primary Program, after such time as the Pilot Program is completed.

It is noted that the FCC *Public Notice Bridge Funding FCC Pilot DA-12-273* anticipates elements of this issue:

The Wireline Competition Bureau (Bureau) seeks comment on whether to fund Rural Health Care Pilot Program (Pilot Program) participants who will exhaust funding allocated to them before or during funding year 2012 (July 1, 2012-June 30, 2013). This funding would maintain support for qualifying Pilot Program participants, on an interim basis, during the 2012 funding year **to provide time to establish a process to transition them into the permanent Rural Health Care support mechanism (RHC support mechanism).**

An immediate point to be noted is the potential confusion regarding the definition of an RHCPP participant: The IRHN is a participant, and is a consortia of rural HCPs, each of whom could also be considered a participant, we assume.

In this filing, the IRHN seeks to address the situation that occurs when a particular HCP that has, in the past, participated individually in the Primary Program, and then becomes part of the IRHN, seeks to request, after the Pilot has been completed, to participate individually in the Primary Program. This does not occur until the HCP has been successfully transitioned onto the IRHN, onto the new network. Prior to this point, the particular HCP has stopped participation in the Primary Program. At some point after this transitioning has been accomplished, the individual HCP will seek to, once again, participate in the Primary Program (but not at the same time, in the same months, so to speak).

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The following language is from Paragraph 14 of FCC Order 06-144, Docket 02-60, adopted September 26, 2006:

This is consistent with the Commission's conclusion in the May 8th Universal Service Order that we have authority to implement a program of universal service support for infrastructure development as a method to enhance access to advanced services under section 254(h)(2)(A).21 Because many health care providers would be unable to access certain telehealth services without deployment of new broadband facilities, **the pilot program will support construction of those facilities.**22

So the Pilot Program supports the IRHN and other Pilot Projects in the *"construction of those facilities."*

After the construction of those facilities, and *after* the individual HCP has been transitioned successfully onto the newly constructed facilities, the individual HCP still has to pay a significant monthly sum (for a small rural HCP) to obtain the high-speed broadband services of the new network from the IRHN.

Without these monthly recurring fees paid by the individual HCPs, the sustainability plan for the IRHN could not exist.

One of the requirements for Pilot Program funding was that each project must have a viable financial sustainability plan. The IRHN has such a plan, and like most or perhaps all Pilot Projects, it is dependent upon monthly "revenues" from the individual hospitals and clinics that are connected to the IRHN in order to sustain its operations and continue to expand.

Here is the scenario the IRHN envisions:

HCP Hospital X participates in the Primary Program. As of a pre-determined date, agreed upon by all parties including USAC, Hospital X ceases participation in the Primary Program for some period of time, while it is being connected to the IRHN. After successful connection to the newly constructed facilities, Hospital X can then begin to participate in the Primary Program once again, based upon the HCP's monthly cost for services.

As such, the HCPs would be allowed to be subsidized for 25% of their recurring monthly cost for internet access by virtue of their connection to the IRHN, and, should this percentage be increased to 50% in the future, at that time the HCP's subsidization would be likewise increased.

Final Comment:

As has often been said, the RHCPP is a Pilot Program. In the documents cited herein, and related FCC publications, there is language alluding to the need to "provide time to establish the process" of the

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transition or adjustment of various elements of the RHC programs to other elements of RHC programs. This is a good thing. As new opportunities are provided by the FCC to improve rural access to health care, there may be new challenges to be met to fine-tune the resulting procedures. This is to be expected, and may indeed be seen as evidence that the objectives are, in reality, being attained.

The IRHN assumes that the FCC, having created the RHCPP, has a strong interest in supporting the HCPs in their ability to make effective use of the newly constructed RHCPP facilities. We hope these comments are helpful toward that end.

The IRHN appreciates your time, and appreciates the immense opportunity that the Rural Health Care Pilot Program has provided. The IRHN seeks only to assist in the strengthening of this initiative by seeking assurances that the Primary Program will provide a vehicle for supporting individual HCPs when the Pilot is completed.

Thank you, and please do not hesitate to contact us if additional information would be helpful.

Sincerely,

Alan Kraus

Alan Kraus
Project Coordinator
Illinois Rural HealthNet

Prepared by:

Douglas G. Power
Assistant Project Coordinator
Illinois Rural HealthNet

cc: Christianna Barnhart, FCC
Chin Yoo, FCC
Linda Oliver, FCC